STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING _____ B. WING _____	R-C 05/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00087744 completed on 3/23/2011. This visit was in conjunction with a PSR to the Investigation of Complaint IN00086657 completed on 3/9/2011. Complaint IN00087744: Corrected Survey dates: May 4 and 5, 2011 Facility number: 001145 Provider number: 155616 AIM number: 200120200 Survey team: Gloria J. Reisert MSW/TC Donna Groan RN (5/5/2011) Avona Connell RN Dorothy Navetta RN Census bed type: SNF/NF: 70 Residential: 15 Total: 85 Census payor type: Medicare: 12 Medicaid: 50 Other: 23 Total: 85 Sample: 8 Landmark Nursing and Rehabilitation was found to be in compliance with 42 CFR Part 483,	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	**201 E ELM ST NEW ALBANY, IN 47150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Subpart B and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00087744. Quality review completed 5-9-11 Cathy Emswiller RN	{F 000}		